

## Medicare Savings Program

Louisiana's Medicare Savings Program helps pay your Medicare premium and may pay your Medicare co-pays and deductibles. This program will not cost you anything. It does not cover medicine.

### How to Apply

- ❖ **Online** –  
www.Medicaid.DHH.Louisiana.gov
- ❖ **Mail** – Mail the application and documents of proof to:  
**Medicare Savings Program**  
**P.O. Box 91278**  
**Baton Rouge, LA 70821-9278**
- ❖ **FAX** – Fax the application and documents of proof to:  
**1-877-523-2987** (toll free)
- ❖ **Drop Off** – Drop off the application and documents of proof at your local Medicaid office. To find the closest office call us at **1-888-342-6207**, or visit [www.Medicaid.DHH.Louisiana.gov](http://www.Medicaid.DHH.Louisiana.gov).

## To Qualify

- ❖ You must have Medicare Hospital Insurance (Part A) or be eligible to get it. Look on your Medicare card or call Social Security toll free at 1-800-772-1213 if you are not sure.
- ❖ Your income needs to be less than \$931 single or \$1261 married for us to pay your Medicare premium, co-pays, and deductibles.

- ❖ Your income needs to be less than \$1257 single or \$1703 married for us to pay only your Medicare premium.

The income amounts go up every April. If your income is more than these amounts, you may still qualify. It is best to apply.

- ❖ The things you own must be worth less than \$6,940 if you are single or \$10,410 if you are married.

We count things like bank accounts, and extra property. **(One vehicle and home property is not counted.)**

## After We Get Your Application

We will check your application and let you know if we need anything else. Once we have everything we need, we will make a decision as fast as we can. We will send you a letter to let you know if you qualify. If you qualify, your case will be reviewed every year.

The information you give us on your application and everything you send us will be kept confidential. We are required by law to keep it private.

## Help with Prescriptions

To find out about Medicare's Prescription Drug Plan, call 1-800-633-4227. If you are deaf or hard of hearing and have a TTY text telephone, call 1-877-486-2048.

## Your Rights

If you think the decision we make is unfair, not correct or made too late, you may ask for a Fair Hearing.

- ❖ Call the Medicare Savings Program office at 1-888-342-6207; and/or
- ❖ Write to  
LA DHH Bureau of Appeals  
P. O. Box 4183  
Baton Rouge, LA 70821-4183

Medicaid is an equal opportunity program. We can't treat you differently because of your race, color, sex, age, disability, religion, nationality or political beliefs. If you think we have:

- ❖ Call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019;
- ❖ Call or write to your local Medicaid office; and/or
- ❖ Write to:  
LA Department of Health & Hospitals  
P.O. Box 4818  
Baton Rouge, LA 70821-4818

¿Necesita traductor de español?  
Llame al 1-877-252-2447.

Quý vị có cần thông dịch viên  
người Việt không? Nếu cần xin  
gọi số  
1-877-252-2447.

This public document was published at a total cost of \$7,500.00. Fifty thousand (50,000) copies of this public document were published in this first printing at a cost of \$22,500.00. The total cost of all printings of this document, including reprints, is \$ 7,500.00. This document was published by Office of State Printing, 950 Brickyard Lane, Baton Rouge, LA 70804 to advise applicants, recipients and other individuals of Medicare Savings coverage available through the Medicaid Program under authority of 42 CFR 435.905 (a)(1). This material was printed in accordance with the standards for printing by state agencies established pursuant to R.S. 43:31. This material was printed according to standards for printing by State agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with provisions of Title 43 of the Louisiana Revised Statutes.



BHSF Form 1-MB Cover  
Rev. 04/12  
Prior Issue Obsolete

## Application for Louisiana Medicaid's



Get Help with  
Medicare Premiums,  
Co-pays, &  
Deductibles

**1-888-544-7996**

**[www.MSP.DHH.Louisiana.gov](http://www.MSP.DHH.Louisiana.gov)**

# Louisiana Medicaid Medicare Savings Program Application

Use this application to apply for Medicaid to pay your Medicare premiums, co-pays, and/or deductibles. **You must have or be eligible to get Medicare Part A to get this type of Medicaid.** This is a free program. It does not cover medicine.

## To apply using this application:

1. **Fill out and sign with a black ink pen.**
2. **Send us the application and proof of income and health insurance.**

Please trust that the information you give us on this application and everything you send us will be kept confidential. We are required by law to keep it private.

★★★★★★★★★★  
**Questions? Need Help?**  
**Call 1-877-252-2447**  
**TTY Text Telephone for the**  
**Hearing Impaired,**  
**Call 1-800-220-5404**  
★★★★★★★★★★

What language do you speak best? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other \_\_\_\_\_  
What language do you write best? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other \_\_\_\_\_

## 1. Where did you get this application form?

- ☐ Medicaid Office ☐ Hospital ☐ Pharmacy ☐ Doctor's Office ☐ Friend/Relative  
☐ Internet ☐ Food Stamps Office ☐ Health Unit ☐ Social Security Office  
☐ Business (Store, Work) ☐ Festival/Health Fair ☐ Other \_\_\_\_\_

## 2. Tell us about you (the person applying).

Name \_\_\_\_\_ ☐ Male ☐ Female  
*First Middle Initial Last*

Social Security Number \_\_\_\_\_ Date of Birth (month, day, year) \_\_\_\_\_

☐ Married and living with spouse ☐ Single ☐ Divorced ☐ Widow/Widower

Race/Ethnic Background: (You do not have to answer. You may mark one or more.)

- ☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Hispanic or Latino  
☐ Native Hawaiian or Pacific Islander

## 3. Tell us how to reach you.

Mailing Address \_\_\_\_\_ Apt/Lot \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Parish You Live In \_\_\_\_\_

Best Day and Time to Call Between Hours of 8 a.m. and 4:30 p.m. M-F \_\_\_\_\_

Email Address \_\_\_\_\_

**4. If you are married and living with your spouse, tell us about them in the spaces below. ☐ No Spouse Lives With You - Go to Question 5**

Name (first, middle initial, last) \_\_\_\_\_ ☐ Male ☐ Female

Date of Birth (month, day, year) \_\_\_\_\_ Social Security Number \_\_\_\_\_

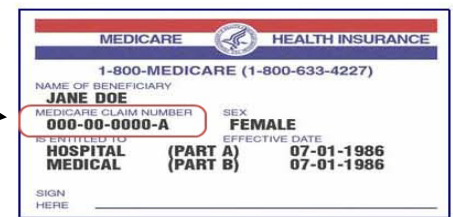
**Does your spouse want to apply for the Medicare Savings Program? ☐ Yes - Fill Out Below ☐ No - Go to Question 5**

Spouse's Race/Ethnic Background: (You do not have to answer. You may mark one or more.) ☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native  
☐ Hispanic or Latino ☐ Native Hawaiian or Pacific Islander

**5. Medicare**

Your Medicare Claim Number (from Medicare card) \_\_\_\_\_

Your Spouse's Medicare Claim Number (from Medicare card) \_\_\_\_\_



**6. Do you have health insurance or a Medicare supplement?**

☐ Yes – Fill out below ☐ No Insurance - Go to Question 7

*If there is more than one insurance, use another sheet of paper.*

Who is covered? ☐ You ☐ Spouse ☐ Both Policyholders' Name \_\_\_\_\_

Coverage Start Date \_\_\_\_\_ How much does it cost for the month? \_\_\_\_\_

Insurance Company Name and Phone Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

What does it cover? ☐ Hospital ☐ Doctor ☐ Medicine ☐ Dental ☐ Ambulance

**7. Does anyone work? ☐ Yes – Fill Out Below ☐ No – Go to Question 8**

Who works?	List Employer & Phone # or Write Self-Employed	How much is paid? (show gross income, before deductions)	How often paid? (weekly, every 2 weeks, monthly)

**8. Does anyone get income (money) from:**

- Social Security • SSI • Veterans' Benefits • Retirement • Pension • Royalties
- Annuities • Rent from Property Owned • Alimony • Worker's Comp
- Unemployment • Money from Friends/Relatives • Other (tell us what it is)

☐ Yes - Fill Out Below ☐ No - Go to Question 9

Who gets it?	What is it?	How much? (show gross income, before deductions)	How often? (weekly, every 2 weeks, monthly)

9. Has anyone applied for income such as Social Security or Veterans' benefits, but they did not get it, yet? ☐ Yes - Fill Out Below ☐ No - Go to Question 10

Who? \_\_\_\_\_ What is it? \_\_\_\_\_

10. Has anyone applying ever received SSI (Supplemental Security Income)?  
If yes, who? \_\_\_\_\_

11. Do you or your spouse own a car, truck, boat, or other vehicle? ☐ Yes - Fill Out Below ☐ No - Go to Question 12 *If more than 3, use another sheet of paper.*

Owner(s)	Year	Make	Model	Value	Amount Owed
				\$	\$
				\$	\$
				\$	\$

12. Does anyone have any of the things listed below? If Yes, give us the following information.

Item	Company Name, Bank Name, Phone Number; and/or Description	Account/ Policy Number	Who does it belong to?	What is the value?
Checking Account <input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Savings Account <input type="checkbox"/> Yes <input type="checkbox"/> No				\$
Trust Funds/ Stocks/Bonds <input type="checkbox"/> Yes <input type="checkbox"/> No				\$

Item	Company Name, Bank Name, Phone Number; and/or Description	Account/ Policy Number	Who does it belong to?	What is the value?
Annuities, Retirement accounts <input type="checkbox"/> Yes <input type="checkbox"/> No (IRA, Keogh, 401-K)				\$
Funeral/Burial Plans <input type="checkbox"/> Yes <input type="checkbox"/> No (bank account, pre-need, burial contract with funeral home, etc.)				\$
Other <input type="checkbox"/> Yes <input type="checkbox"/> No (CDs, mineral rights, etc.)				\$

**13. Does anyone have any life insurance/burial insurance policies? ☐ Yes - Fill Out Below ☐ No - Go to Question 14** *If more than 2, use another sheet of paper.*

Policy Owner	Person Covered	Insurance Company	Policy Number	Face Value
				\$
				\$

**14. Does anyone own property other than home property or have an ownership interest in property (from an inheritance)? ☐ Yes - Fill Out Below ☐ No - Go to Question 15**

Address	Owner	Value	Amount Owed
		\$	\$
		\$	\$

**15. Does anyone have any medical bills for care or services that were received in the last 3 months? ☐ Yes ☐ No If Yes, what is the amount? \_\_\_\_\_**

**This is the end of the application. SIGN BELOW**

By signing this application I am giving my permission to the State of Louisiana and its agents to make contacts to verify the information given on this application. Under penalty of perjury I certify all information I have given is true. I also acknowledge that I have received and read the Rights and Responsibilities below.



**Sign Your Name Here: \_\_\_\_\_ Date: \_\_\_\_\_**

***If you are married and your spouse is applying, he/she will sign below.***



**Spouse Signs Here: \_\_\_\_\_ Date: \_\_\_\_\_**

## Send Us the Application and These Things

Proof of income for you and your spouse and any health insurance cards, including Medicare supplements.

## Where to send the application and proofs.

**Mail to:** P.O. Box 91278, Baton Rouge, LA 70821-9278

**Fax to:** 1-877-523-2987 (toll-free)

**Drop off at:** Your local Medicaid office or Application Center. For the office closest to you, call 1-888-342-6207. If you are deaf or hard of hearing and use a TTY text telephone, call 1-800-220-5404.

## YOUR RIGHTS AND RESPONSIBILITIES

### WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU

**REPORTING THE TRUTH:** You state that the information you give on the application form is true and correct. You understand if you on purpose give information that is not true OR if you on purpose do not tell information that you are supposed to, you and/or the person(s) applying may get health benefits that you or they should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

**VERIFICATION OF INFORMATION:** You understand that the information you give about you and/or the person(s) applying will be checked. You agree to help do that and let Medicaid get information it needs from government agencies, employers, medical providers, and others.

**SOCIAL SECURITY NUMBERS:** You understand Social Security numbers will only be used to get information from other government agencies to make a decision on eligibility for you and/or the person(s) applying for Medicaid.

**PAYMENT OF MEDICAL CARE BY A THIRD PARTY:** You understand by accepting Medicaid, the Department has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you and/or the person(s) applying.

**REPORTING CHANGES:** You agree to tell Medicaid within 10 days of these changes: 1) if anyone getting Medicaid moves out of state; 2) changes in mailing or home address; 3) when someone moves in or out of the home; 4) changes in health insurance and premiums; 5) changes in income; and 6) changes in things owned by anyone who gets Medicaid who is disabled or over age 64.

### WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID

**RIGHT TO A FAIR HEARING:** You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

**NO DISCRIMINATION:** You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.

## IMPORTANT PHONE NUMBERS

	PHONE NUMBER	TTY TEXT TELEPHONE
Medicaid Services	1-888-342-6207	1-800-220-5404
Medicare	1-800-MEDICARE (1-800-633-4227)	1-877-486-2048

## IMPORTANT WEB SITES

Other Medicaid Programs	<a href="http://www.Medicaid.DHH.Louisiana.gov">www.Medicaid.DHH.Louisiana.gov</a>
Apply for or Renew Your Medicaid	<a href="http://www.Medicaid.DHH.Louisiana.gov">www.Medicaid.DHH.Louisiana.gov</a>



Department of Health and Hospitals  
Voter Registration Declaration (Optional)

If you fill it out, your answers will not affect the benefits you get from the  
*Louisiana Department of Health and Hospitals.*

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

- If you checked "Yes," please complete the attached form called the "Louisiana Mail Voter Registration Application." You may mail your completed Voter Registration Application to your local Registrar of Voters listed on the application or mail it to the Department of Health and Hospitals.
- **IF YOU DO NOT CHECK EITHER BOX YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. **You may call us toll-free at 1-888-342-6207.** The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you choose to register to vote at this time, the information about the location where you completed the application to register will remain confidential and will only be used for voter registration purposes. If you choose not to register to vote, that information will also be kept confidential.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

Louisiana Secretary of State  
Commissioner of Elections  
P.O. Box 94125  
Baton Rouge, LA 70804-9125  
Phone: (toll-free) 1-800-883-2805

\_\_\_\_\_  
Print Your Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Sign Your Name

\_\_\_\_\_  
Today's Date

**ACADIA**

Courthouse #115  
Crowley, LA 70526-4363  
(337) 788-8841  
**ALLEN**  
P. O. Box 150  
Oberlin, LA 70655-0150  
(337) 639-4966

**ASCENSION**

828 S. Irma Blvd. #205  
Gonzales, LA 70737-3631  
(225) 621-5780

**ASSUMPTION**

P. O. Box 578  
Napoleonville, LA 70390-0578  
(985) 369-7347

**AVOUELLES**

312 N. Main St. #E  
Marksville, LA 71351-2409  
(318) 253-7129

**BEAUREGARD**

P. O. Box 952  
DeRidder, LA 70634-0952  
(337) 463-7955

**BIENVILLE**

P. O. Box 697  
Arcadia, LA 71001-0697  
(318) 263-7407

**BOSSIER**

P. O. Box 635  
Benton, LA 71006-0635  
(318) 965-2301

**CADDO**

P.O. Box 1253  
Shreveport, LA 71153-1253  
(318)226-6891

**CALCASIEU**

1000 Ryan St. #7  
Lake Charles, LA 70601-5250  
(337)437-3572

**CALDWELL**

P. O. Box 1107  
Columbia, LA 71418-1107  
(318) 649-7364

**CAMERON**

P. O. Box 1  
Cameron, LA 70631-0001  
(337) 775-5493  
**CATAHOULA**  
P. O. Box 215  
Harrisonburg, LA 71340-0215  
(318) 744-5745

**CLAIBORNE**

507 W. Main Suite 1  
Homer, LA 71040-3914  
(318) 927-3332

**CONCORDIA**

4001 Carter St. #4  
Vidalia, LA 71373-3021  
(318) 3367770

**DESOTO**

105 Franklin St.  
Mansfield, LA 71052-2046  
(318) 872-1149

**E. BATON ROUGE**

222 St. Louis #201  
Baton Rouge, LA 70802-5860  
(225) 389-3940

**E. CARROLL**

P. O. Box 708  
Lake Providence, LA 71254-0708  
(318) 559-2015

**E. FELICIANA**

P. O. Box 488  
Clinton, LA 70722-0488  
(225) 683-3105

**EVANGELINE**

200 Court St. Ste. 102  
Ville Platte, LA 70586-4463  
(337) 363-5538

**FRANKLIN**

Courthouse  
6560 Main St.  
Winnsboro, LA 71295-2750  
(318) 4354489

**GRANT**

Courthouse  
200 Main St.  
Colfax, LA 71417-1828  
(318) 627-9938

**IBERIA**

300 S. Iberia St. #110  
New Iberia, LA 70560-4543  
(337) 369-4407

**IBERVILLE**

P. O. Box 554  
Plaquemine, LA 70765-0554  
(225) 687-5201

**JACKSON**

500 E. Court St. #102  
Jonesboro, LA 71251-3400  
(318) 259-2486

**JEFFERSON**

P. O. Box 10494  
Jefferson, LA 70181-0494  
(504) 736-6191

**JEFFERSON DAVIS**

302 N. Cutting Ave.  
Jennings, LA 7054-65361  
(337) 824-0834

**LAFAYETTE**

1010 Lafayette #313  
Lafayette, LA 70501-6885  
(337) 291-7140

**LAFOURCHE**

307 W. 4th St. #101  
Thibodaux, LA 70301-3105  
(985) 447-3256

**LASALLE**

P. O. Box 2439  
Jena, LA 71342-2439  
(318) 992-2254

**LINCOLN**

100 W. Texas Ave.  
Ruston, LA 71270-4463  
(318) 251-5110

**LIVINGSTON**

P. O. Box 968  
Livingston, LA 707540968  
(225) 686-3054

**MADISON**

100 N. Cedar St.  
Tallulah, LA 71282-3892  
(318) 574-2193

**MOREHOUSE**

129 N. Franklin  
Bastrop, LA 71220-3815  
(318) 281-1434

**NATCHITOCHES**

P. O. Box 677  
Natchitoches, LA 71458-0677  
(318) 357-2211

**ORLEANS**

1300 Perdido #1W23  
New Orleans, LA 70112-2127  
(504) 658-8300

**OUACHITA**

122 St John St #114  
Monroe, LA 71201-7342  
(318) 3271436

**PLAQUEMINES**

P. O. Box 989  
Port Sulphur, LA 70083-0989  
(504) 564-6957

**POINTE COUPEE**

211 E. Main St.  
New Roads, LA 70760-3661  
(225) 638-5537

**RAPIDES**

701 Murray St.  
Alexandria, LA 71301-8099  
(318) 473-6770

**RED RIVER**

P. O. Box 432  
Coushatta, LA 71019-0432  
(318) 932-5027

**RICHLAND**

P. O. Box 368  
Rayville, LA 71269-0368  
(318) 728-3582

**SABINE**

400 Capitol St. #107  
Many, LA 71449-3099  
(318) 256-3697

**ST. BERNARD**

8201 W. Judge Perez Rm. 104  
Chalmette, LA 70043-1696  
(504) 278-4231

**ST. CHARLES**

P. O. Box 315  
Hahnville, LA 70057-0315  
(985) 783-2731

**ST. HELENA**

P. O. Box 543  
Greensburg, LA 70441-0543  
(225) 222-4440

**ST. JAMES**

P. O. Box 179  
Convent, LA 70723-0179  
(225) 562-2330

**ST. JOHN**

1801 W. Airline Hwy  
LaPlace, LA 70068-3344  
(985) 652-9797

**ST. LANDRY**

P. O. Box 818  
Opelousas, LA 70571-0818  
(337) 948-0572

**ST. MARTIN**

Courthouse  
415 S. Martin St.  
St. Martinville, LA 70582-4549  
(337) 394-2204

**ST. MARY**

500 Main St. #301  
Franklin, LA 70538-6144  
(337) 828-4100

**ST. TAMMANY**

701 N. Columbia St.  
Covington, LA 70433-2709  
(985) 809-5500

**TANGIPAHOA**

P. O. Box 895  
Amite, LA 70422-0895  
(985) 748-3215

**TENSAS**

P. O. Box 183  
St. Joseph, LA 71366-0183  
(318) 766-3931

**TERREBONNE**

P. O. Box 9189  
Houma, LA 70361-9189  
(985) 873-6533

**UNION**

P. O. Box 235  
Farmerville, LA 71241-0235  
(318) 368-8660

**VERMILION**

100 N. State St. #120  
Abbeville, LA 70510  
(337) 898-4324

**VERNON**

P. O. Box 626  
Leesville, LA 71496-0626  
(337) 239-3690

**WASHINGTON**

Courthouse Bldg.  
900 Washington St.  
Franklinton, LA 70438  
(985) 839-7850

**WEBSTER**

P. O. Box 674  
Minden, LA 71058-0674  
(318) 377-9272

**W. BATON ROUGE**

P. O. Box 31  
Port Allen, LA 70767-0031  
(225) 336-2421

**W. CARROLL**

P. O. Box 71  
Oak Grove, LA 71263-0071  
(318) 428-2381

**W. FELICIANA**

P. O. Box 2490  
St. Francisville, LA 70775-2490  
(225) 635-6161

**WINN**

Courthouse Room 105  
Winnfield, LA 71483-3238  
(318) 628-6133

**OFFICIAL USE ONLY**

**Address Change**

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**Name Change**

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**Party Change**

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**Remarks**

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Circle One: PA MV RG SDA SS

Received by: \_\_\_\_\_

PLACE IN AN ENVELOPE AND MAIL TO YOUR  
REGISTRAR OF VOTERS

USE THIS FORM TO: 1) register to vote 2) change your address 3) request a name change 4) change party affiliation

**TO REGISTER TO VOTE AND BE ELIGIBLE TO VOTE YOU MUST:** 1) be a United States citizen 2) be at least 17 years old to register but must be 18 years old to vote 3) not be under an order of imprisonment for conviction of a felony 4) not be under a judgment of full interdiction or limited interdiction where your right to vote has been suspended 5) reside in the state and parish in which you seek to register and vote.

**INSTRUCTIONS FOR COMPLETING THIS FORM:** All information except your signature should be printed clearly in ink, preferably black, or typed. Fill in all boxes that apply to you.

**Box 1:** Indicate whether you are a citizen of the United States of America. Indicate whether you will be 18 years of age on or before election day.

**Box 2:** Provide full name. Do not use initials for middle or maiden name.

**Box 3:** 'Residence Address' means the address where you live and are registering to vote. If you claim a homestead exemption, you must list the address of that residence. Do not use a post office box for your 'Residence Address'. If you use a rural route and box number, draw a map in the space labeled 'Give Location.' Write in the names of the crossroads (streets) nearest to where you live. Draw an X to show where you live. Use a dot to show any schools, churches, stores or landmarks near where you live and write the name of the landmark. Check the box provided if mail is not delivered to your residence address by the post office. Complete 'Mailing Address' only if it is different from the 'Residence Address' or if mail is not delivered to your residence address.

**Box 4:** Provide your age.

**Boxes 6 & 14:** You must provide your Louisiana driver's license number, if issued. If not issued, you must provide at least the last four digits of your social security number, if issued. The full social security number may be provided on a voluntary basis. If neither a social security number nor a Louisiana driver's license number has been issued, and this form is submitted by mail, and you are registering to vote for the first time, in order to avoid additional identification requirements for first time voters, attach either a) a copy of a current and valid photo identification or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

**Boxes 8, 12 & 13:** The items 'race/ethnic origin', 'home phone' and 'daytime phone' are not required but are helpful.

**Box 9:** If you do not complete this item, your party affiliation will be listed as 'none', unless you are presently registered with a party affiliation and no change is being made today. If you are not registering with a political party, circle 'none'. The recognized political parties are Democrat, Green, Libertarian, Reform and Republican or you may specify any other party affiliation.

**Box 18:** If you are using this form to request a change of name, you must print the name to be changed here.

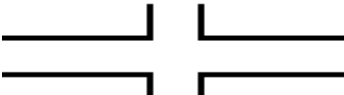
**Box 19:** Date and sign the card with your signature or mark.

If returned by mail, place in an envelope and mail to the appropriate registrar of voters at the address found on the reverse side of this card. If you have not been issued a social security number or Louisiana driver's license number, you must mail the required documentation with your application. Your application or envelope must be postmarked 30 days prior to the first election in which you seek to vote based on the residence listed on this application.

**NOTE:** 1. If you decline to register to vote, this fact will remain confidential and will be used only for voter registration purposes. If you register to vote, the office where your application was submitted will remain confidential and will be used only for voter registration purposes. 2. Your social security number will also remain confidential and is intended to be used for voter registration purposes only.

**QUESTIONS?** Call your Parish Registrar of Voters OR call the Department of State at 1-800-883-2805 or (225) 922-0900.

**COMPLETE AND CHECK ALL APPLICABLE BOXES AND TEAR ALONG PERFORATED LINE BEFORE MAILING.**

<b>LOUISIANA MAIL VOTER REGISTRATION APPLICATION FORM #04</b>				<b>OFFICIAL USE ONLY</b> COMP REG # _____ Reg Type _____ Wd/ Dist _____ Pct _____ In _____ Out _____			
1 Are you a citizen of the United States of America? YES <input type="checkbox"/> NO <input type="checkbox"/> Will you be 18 years of age on or before election day YES <input type="checkbox"/> NO <input type="checkbox"/> If you checked no in response to either of these questions, DO NOT COMPLETE THIS FORM.							
2 NAME OF APPLICANT (PLEASE PRINT NAME) LAST _____ First _____ FULL MIDDLE OR MAIDEN _____				<b>GIVE LOCATION</b> 			
3 RESIDENCE ADDRESS (MUST BE ADDRESS WHERE YOU CLAIM HOMESTEAD EXEMPTION, IF ANY) HOUSE OR APT. NO. & STREET _____ CITY OR TOWN _____ STATE _____ ZIP _____							
IF NO mail delivery to residential address, check here: ( ) _____ MAILING ADDRESS IF DIFFERENT _____							
4 AGE _____	5 DATE OF BIRTH MONTH _____ DAY _____ YEAR _____		6 * SOCIAL SECURITY # (CIRCLE ONE) NO _____ YES # _____	7 SEX (CIRCLE ONE) MALE _____ FEMALE _____	8 ** RACE/ ETHNIC ORIGIN (CIRCLE ONE) WHITE _____ BLACK _____ ASIAN _____ HISPANIC _____ AMER. INDIAN _____ OTHER: _____		
9 PARTY AFFILIATION (CIRCLE ONE) DEM GRN LBT RFM REP NONE OTHER (SPECIFY) _____			10 APPLICANTS'S PLACE OF BIRTH CITY OR TOWN _____ PARISH OR COUNTY _____ STATE _____ COUNTRY _____			11 MOTHERS MAIDEN NAME _____	
12 ** HOME PHONE _____			13 ** DAYTIME PHONE _____		14 LA DRIVERS LICENSE / I.D. # (CIRCLE ONE) NO _____ YES # _____		
15 Will you require assistance at the polls? (CIRCLE ONE) NO _____ YES _____ IF YES, GIVE REASON _____							
16 LAST RESIDENCE ADDRESS ADDRESS _____			17 PLACE OF REGISTRATION PARISH OR COUNTY _____ STATE _____		18 FOMER REGISTERED NAME, IF APPLICABLE _____		
<b>AFFIRMATION :</b> I do hereby solemnly swear or affirm that I am a United States citizen, that I am at least 17 years old, that I am not currently under an order of imprisonment for conviction of a felony, that I am not currently under a judgment of full interdiction or limited interdiction where my right to vote has been suspended, that I am a bona fide resident of this state and parish, and that the facts given by me on this application are true to the best of my knowledge and belief. If I have provided false information, I may be subject to a fine of not more than \$1,000 (\$2,500 for subsequent offense) or imprisonment for not more than 1 year.							
19 SIGN YOUR NAME IN BOX AT RIGHT DATE: _____ / _____ / _____							
20 IF YOU ARE UNABLE TO SIGN YOUR NAME, TWO WITNESSES TO YOUR MARK MUST SIGN HERE WITNESS SIGNATURE _____ WITNESS SIGNATURE _____							
* Last 4 digits of the social security number required if no LA driver's license issued; social security number is intended to be used for voter registration purposes only Full # Optional ** OPTIONAL LR-1M (REV. 1/11, 7/11) R.S. 18:104 FORM #04							